APPLICATION FOR THE ADULT
*S*EXUAL *A*SSAULT *N*URSE *E*XAMINER PROGRAM
Massachusetts Department of Public Health

PLEASE TYPE or PRINT

Name _____

Address _____

Home Telephone _____ Cellphone _____

Work Address _____

Work Telephone _____ Email Address:_____

MA RN License # _____Social Security # _____

EXPERIENCE

List all previous positions in emergency departments, psychiatric nursing, women's health and any experience working with adult victims of sexual assault. Most recent experience first.

Title/Position Agency Name and Address Dates

_____

_____

_____

_____

EDUCATION

School Name and Address Degree/Certificate Dates Attended

_____

_____

_____

_____

PROFESSIONAL LIABILITY INFORMATION

Within the past *three years*:

1. Have any professional liability suits been filed against you which are pending adjudication?
   ☐ NO ☐ YES*

2. Have any judgments or settlements been made against you in a professional liability suit case within the past 10 years?
   ☐ NO ☐ YES*

Please note that professional liability insurance is <u>required</u> for all SANE Program practitioners.

Please check the region you would like to provide SANE services. You must be able to respond to the designated SANE site in that region within 40-60 minutes of being paged. (see designated sites list for Hospitals)

❑ Western	❑ Northeast	❑ Southeast
❑ Central	❑ Boston	❑ Cape/Islands

PROFESSIONAL LICENSURE

1. Has your nursing license ever been limited, suspended, revoked, denied or subjected to probationary conditions in any jurisdiction? ☐ NO ☐ YES*

2. Have your privileges at any hospital ever been suspended, diminished, revoked or denied renewal? ☐ NO ☐ YES*

3. Have you ever voluntarily relinquished your Allied Health Professional staff membership, clinical responsibilities, professional society membership or professional license?
   ☐ NO ☐ YES*

*** If the answer to any of the above questions is YES, please explain on a separate page.**

Foreign Language Competency

List the foreign language(s) you speak and state level of fluency.

_____

Pelvic Exam Preceptor (optional)

If you've identified a preceptor by this point in the application process, please list below:

_____

Name and Title Address Telephone

Please check and attach these items to this application:

- ☐ Current resume
- ☐ Copy of current Mass. RN license
- ☐ Copy of current liability insurance policy front sheet ($1 million/$3 million coverage)

or

- ☐ I have applied for nursing liability coverage
- ☐ Other (specify) _____

Please check all that apply:

- ☐ I am interested in becoming a certified SANE.
- ☐ In addition to becoming a SANE, I am interested in precepting students for sexual assault exams. (Preceptors will be chosen after SANE certification is complete).
- ☐ I am interested in precepting SANE students for the pelvic exam.

IMMUNIZATION STATUS

Please be prepared to provide written proof of immunizations/titers for the following ***once accepted into the training program***:

Hepatitis B Vaccine (completion of series of three)
MMR (at least one dose)
Measles (two doses)
Tetanus/Diphtheria Booster (within last 10 years)
Tuberculosis test
Chicken pox/ varicella vaccine or titer

If you do not have this information at the time you are completing your application, please submit your application first and this immunization status documentation may follow. Documentation of positive titres, completed immunizations, and religious or medical exemptions must be submitted and on file prior to completion of the training course.

CONDITIONS OF ADULT SANE APPLICATION

In requesting admission to a Department of Public Health-approved Sexual Assault Nurse Examiner Program, I agree to each of the following provisions:

1. Affirm that the information submitted by me in this application is true to the best of my knowledge and belief and is furnished in good faith.

2. Release from liability any and all individuals and organizations who, in good faith and without malice, provide information to the Department of Public Health concerning my professional competence, ethics, character, and other qualifications for a Sexual Assault Nurse Examiner.

3. Give permission for the DPH to conduct a Criminal Offense Record Investigation (CORI).

4. If accepted to the SANE Program, I commit to the following terms of the Sexual Assault Nurse Examiner program:

    a. Upon date of certification as a SANE I will serve at least one year as a SANE. I understand this commitment requires on call duties for the equivalent of two 24 hour periods/per month.

    b. I will assume responsibility for renewing my nursing license, and carrying nursing malpractice insurance equal to 1 million/3 million for the duration of the SANE certification period.

    c. I will submit to periodic quality review of my performance as a SANE nurse by the DPH and/or its designee.

    d. I will comply with the SANE data reporting requirements in a timely manner.

    e. I will submit billing materials on the first day of every month to reflect all hours on-call and each SANE examination I render.

    f. If necessary, I will apply for allied health privileges at the hospital(s) where I am a SANE.

    g. I understand that my certification as a SANE can be revoked by the MA Department of Public Health SANE Program. I agree that upon either resignation and/or termination, I will return all SANE Program supplies and equipment within 30 days.

Print Name:_____ **Signature:**_____ **Date:**_____

PRECEPTOR APPLICANTS ONLY

In addition to Conditions 1 through 4 listed above, I agree to:

5. Act as a SANE preceptor/SANE for sexual assault exams.
6. Act as a SANE preceptor/SANE for a duration of at least two years after certification.
7. Submit evaluation forms in a timely manner for each SANE student precepted.
8. Affirm that my on-call commitment will be the same as my commitment as a SANE.
9. Submit billing materials on the first day of every month to reflect all hours on-call and each SANE examination for which I serve as a preceptor.

Print Name:_____ **Signature:**_____ **Date:**_____

Please return this application to:

Ginhee Sohn
SANE PROGRAM
MA DEPT. OF PUBLIC HEALTH
250 WASHINGTON ST., 4th FL.
BOSTON, MA 02108